SECTION 2000
STATUTORY BASIS

The Wisconsin inpatient hospital payment system is designed to promote the objectives of the State statutes regarding payment for hospital services (Chapter 49, Wis. Stats) and to meet the criteria for Title XIX hospital payment systems contained in the Federal Social Security Act and Federal Regulations (Title 42 CFR, Subpart C). The inpatient payment system will comply with all applicable Federal and State laws and regulations and will reflect all adjustments required under these laws and regulations.

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SECTION 3000
DEFINITIONS

Annual Rate Update. The process of annually adjusting hospital payment rates to be effective July 1 of each year based on more current cost reports and/or other information relevant to hospital reimbursement.

Border Status Hospital. A hospital not located in Wisconsin which has been certified by the WMAP as a border-status hospital to provide hospital services to WMAP recipients. (Reference, HSS 105.48, Wis.Adm.Code) Border status hospitals are differentiated between major providers and minor providers as described in §3500.

Children's Hospital. Acute care hospital whose primary activity is to serve children.

Department. The Wisconsin Department of Health and Family Services (or its agent); the State agency responsible for the administration of the Wisconsin Medical Assistance Program (WMAP).

DRG. DRG means Diagnosis Related Groups which is a patient classification system that reflects clinically similar groupings of services that can be expected to consume similar amounts of hospital resources.

Hospital-Specific DRG Base Rate. The payment rate per discharge which will be calculated for and assigned to each hospital by the Department for the rate year. This is the rate by which a DRG weight is multiplied to establish the amount of payment for an individual inpatient stay. Some provisions may allow this rate to change during the rate year.

IMD. Institution for Mental Disease, as defined in 42 CFR 435.1009. When used in this Plan, IMD means "hospital IMD".

Non-Border Status Hospital. A hospital not located in Wisconsin and which has not been certified by the WMAP as a border status hospital.

Prospective Rate per Diem. The hospital-specific rate for each day of service.

Rate Year. The twelve month period from July 1 through June 30 during which rates established under the annual rate update are to be effective for most, if not all, hospitals.

Rehabilitation Hospital. A hospital that provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures, and multiple trauma to at least 75% of its patient population. IMD hospitals cannot be considered rehabilitation hospitals under the provisions of this plan.

WMAP. Wisconsin Medical Assistance Program, also referred to as Medicaid, Medical Assistance (MA) or Title XIX.

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SECTION 3500
DIFFERENCES IN RATE SETTING BETWEEN IN-STATE HOSPITALS AND OUT-OF-STATE HOSPITALS

3510 Hospitals Located in Wisconsin

General hospitals and most specialty hospitals located in Wisconsin (in-state hospitals) are reimbursed according to the DRG based payment method described in section 5000 herein. All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000. As of July 1, 1995, organ transplants are paid under the DRG based payment method.

Certain specialty hospitals are reimbursed under a rate per diem methodology, not the DRG based payment system. Rehabilitation hospitals as defined in section 3000 are paid a per diem rate according to section 6300. The State's mental health institutes are paid under the payment rates described in section 6200. State operated hospitals which primarily service military veterans are paid under the payment rates described in section 6250.

Administrative Adjustment of Rates. In-state hospitals may request an administrative adjustment to their payment rates under the criteria described in section 11000. The due dates for requesting adjustments are described in that section.

Use of Cost Report In Rate Setting. An in-state hospital's audited cost report is required for establishing certain components of the hospital's specific payment. The specific components include the disproportionate share adjustment (§5240), the rural hospital adjustment (§5260), outlier payments (§4322), capital cost payments (§5420) and the direct medical education payments (§5520).

3520 Hospitals Not Located In Wisconsin and Border Status Hospitals

Hospitals not located in Wisconsin which provide inpatient services to WMAP recipients may be reimbursed for their services. Certain of these hospitals have been granted "border status" by the WMAP. Others do not have border status under the WMAP (non-border status hospitals)

Non-Border Status Hospitals. Out-of-state hospitals which *do not have border status* are reimbursed under the DRG based payment method described in section 10000 herein. Payment is based on a standard DRG base rate which does not recognize any hospital-specific differences such as capital costs, differences in wage areas and disproportionate share adjustments. A non-border status hospital may request an adjustment for many of these factors through the administrative adjustments described in section 10400.

All non-emergency services at out-of-state hospitals which do not have border status require prior authorization from the WMAP. This differs from the prior authorization requirements for in-state and border status hospitals.

Minor Border Status Hospitals. Border status hospitals are divided into minor and major border status hospitals. Minor border status hospitals are those border status hospitals which do not meet the criteria described below for a major border status hospital. Minor border status hospitals are reimbursed according to section 10000 in the same manner as non-border status hospitals and may request the administrative adjustments to payment rates as described in that section. A minor border status hospital is required to provide an audited cost report to the Department (see §4022).

Major Border Status Hospitals. Major border status hospitals are reimbursed according to the DRG based payment method described under section 5000. This is the same DRG method as is used for in-state hospitals. It provides a rate that takes into account hospital-specific costs for such as capital costs.

Administrative Adjustments To Rates. Major border status hospitals may request administrative adjustments to their payment rates under section 11000.

Use of Cost Report In Rate Setting. As described in section 4000, a major border status hospital must submit a current audited cost reports to the Department for establishing certain components of their payment. The specific components include the disproportionate share adjustment (§5240), outlier payments (§4322), and capital cost payments (§5420).

Criteria For Major Border Status. Major border status hospitals are those border status hospitals which have had 75 or more WMAP recipient discharges or at least $225,000 or greater inpatient charges for services provided to WMAP recipients for the combined two rate years ending in the calendar years preceding the current annual rate update. Not included in these amounts are discharges and charges for: (1) Medicaid HMO covered stays, (2) stays which were paid in full or part by Medicare, (3) stays paid in full by a payor other than Medicare or Medicaid. Paid in full means the amount received by the hospital equals or exceeds the amount the WMAP would have paid for the stay. For each rate year, the Department will assess the discharges and charges of each border status hospital and notify the hospital of its standing as a major or minor border status hospital. For example, the following table shows the years used for a series of annual rate updates.

Annual Rate Update Effective Date	Rate Years Looked At for Discharges and Charges
July 1, 1996	July 1993 to June 1994 and July 1994 to June 1995
July 1, 1997	July 1994 to June 1995 and July 1995 to June 1996

Rehabilitation Hospitals With Border Status. A major border status hospital which the Department determines qualifies as a rehabilitation hospital, as defined in section 3000, will be reimbursed on a prospective rate per diem according to section 6300 otherwise the hospital will be paid under the DRG based payment method of section 5000. A minor border status rehabilitation hospital may request payment at a rate per diem according to section 10469.

Alternative Payments To Border Status Hospitals For Certain Services . For any out-of-state hospital, border status or not, all inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

SECTION 4000
COST REPORTING

4010 General

Every in-state hospital participating in the Wisconsin Medical Assistance Program (WMAP) will prepare a Title XIX cost report. Major border status hospitals will submit their audited Medicare cost reports. Hospitals will be instructed regarding any supplemental worksheets and additional information that may be specifically required by the WMAP.

4020 Cost Report Due Date

4021 In-State Hospitals.
In-state hospital providers must submit the cost report and accompanying supplemental schedules to the Department's audit intermediary by the date required by Medicare for submission of the cost report. If a provider is granted an extension for Medicare, the WMAP will automatically extend its deadline.

4022 Major and Minor Border-Status Hospitals.
Both major and minor border-status hospitals must submit Medicare audited cost reports to the Department within sixty (60) days of the Medicare audit being completed. A hospital not participating in the Medicare program should submit the cost report it provided the Medicaid program in its state. An audit should be considered completed upon the hospital receiving the Medicare audit report. If the hospital is pursuing any appeal of the audited Medicare cost report, the hospital should submit the audited cost report to the Department along with a description of the items being appealed. Send a copy of the audited cost report to:

Hospital Unit
Bureau of Health Care Financing
P.O. Box 309
Madison, Wisconsin 53701-0309.

Audited Cost Report Used In Rate Setting. For major border-status hospitals, the Department uses a hospital's audited cost report on file with the Department to establish rates. If that cost report is for a fiscal year that is more than three years old, the hospital can request an administrative adjustment for use of a more current cost report in rate setting. Such an administrative adjustment is discussed under section 11900, item B (inpatient plan page 43)

4050 Gains and Losses of Depreciable Assets

The Department will not recognize losses or gains from the disposal or sale of a depreciable asset, where the original acquisition cost of the asset sold at a loss is greater than 25% of the facility's original acquisition cost of total current depreciable assets. These losses or gains will not be recognized in the form of a lump sum settlement for prior fiscal years nor will any adjustment be made in the prospective payment. This provision is effective with cost reports for hospital fiscal years beginning on or after the effective date of this plan. This provision does not apply to hospitals and their parent corporations that close or cease to operate as a hospital.

4060 Allowed Capital Cost Upon Change of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a hospital which has undergone change of ownership, Medicare allowable cost principles now in effect or as may be amended govern the allowableness of costs except when provisions of this plan specifically describe a variance from Medicare principles.

SECTION 5000
DRG BASED PAYMENT SYSTEM
FOR IN-STATE HOSPITALS AND MAJOR BORDER STATUS HOSPITALS

5010 INTRODUCTION

A hospital is paid a prospectively established amount for each discharge under the DRG based payment system. In the Department's annual rate update, a "hospital-specific DRG base rate" is calculated for each hospital. This rate is the result of adjusting a "standard DRG group rate" for the wage area of each hospital. In addition, if the hospital qualifies, the rate includes the indirect medical education (§5230), disproportionate share (§5240) or rural hospital adjustments (§5260). As of July 1, 1997, the hospital-specific DRG base rate includes payment for capital costs (§5400) and direct medical education costs (§5500). As of July 1, 1999, the indirect and direct medical education costs are only included in the calculation for in-state hospital-specific DRG base rates.

For each Medicaid recipient's stay, a hospital's specific DRG base rate is multiplied by the relative weighting factor for the diagnosis related group (DRG) which applies to the hospital stay. The result is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high cost cases which are described in sections 5321 through 5324 or for certain very long lengths of stay which are described in sections 5331 through 5334.

5020 HOSPITALS COVERED BY DRG SYSTEM

Most general, specialty and IMD hospital providers in Wisconsin and most major border status hospitals will be paid according to the DRG based payment system described in this section 5000. Minor border status hospitals, out-of-state non-border status hospitals, rehabilitation hospitals, and State operated IMD hospitals and veteran hospitals are not covered by this section 5000.

5030 SERVICES COVERED BY DRG PAYMENTS

All covered services provided during an inpatient stay, except professional services described in §5040, shall be considered hospital inpatient services for which payment is provided under this DRG based payment system. (Reference: Wis. Admin. Code, HSS 107.08(3) and (4))

All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

As of July 1, 1995, organ transplants are covered by the DRG based payment method.

5040 PROFESSIONAL SERVICES EXCLUDED FROM DRG PAYMENTS

Certain professional and other services are excluded from the DRG payment system. Professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded, when the professionals are functioning in the capacity of:

- physicians
- psychiatrists
- psychologists
- physician assistants
- nurse midwives
- chiropractors
- dentists
- optometrists
- hearing aid dealers
- audiologists
- podiatrists
- independent nurse practitioners
- anesthesia assistants
- certified registered nurse anesthetists
- a pharmacy, for take home drugs on the date of discharge
- durable medical equipment and supplies for non-hospital use
- specialized medical vehicle transportation
- air, water and land ambulance

5100 STANDARDIZED DRG PAYMENT FACTORS

Certain standard factors are used in the determining the amount of payment hospitals receive for services covered by the DRG based payment method. The Department adjusts these standard factors for each rate year, July 1 through June 30. They include the DRG grouper, the DRG weights and the standard DRG group rates.

5130 DRG Grouper

The DRG grouper is a patient classification software system which results in a patient stay being classified into one "diagnosis related group" (DRG). The WMAP DRG reimbursement system uses the grouper developed for Medicare based on "major diagnostic categories" (MDCs). For newborns, WMAP has enhanced the grouper's MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period. For psychiatric stays, the grouper's MDC 19, Mental Diseases and Disorders, is also enhanced.

Annually, beginning with July 1, 1992, updated versions of the Medicare grouper will be used by the WMAP. The Medicare grouper version which is released by HCFA for use by Medicare beginning on October 1 of each calendar year will be implemented for MA discharges occurring on and after July 1 of the subsequent calendar year. (For example, on October 1, 1991 HCFA began to use Version IX of the Medicare grouper. Therefore, for dates of discharge on and after July 1, 1992, the WMAP will apply that Version IX grouper.)

5140 DRG Weights

DRG weights reflect the relative resource consumption of each inpatient stay. The weights are determined from an analysis of past services provided by hospitals, the claim charges for those services and the relative cost of those services. Only WMAP recipient inpatient hospital claims are used in order that the weights which are developed are relevant to the types and scope of services provided to WMAP recipients.

Annually, beginning with July 1, 1992, revised DRG weights will be established based on (1) the updated version of the Medicare grouper, (2) more current claims information and (3) more current inpatient hospital cost report information.

Claims Used. Claims for a period of at least three years for WMAP certified hospital providers in Wisconsin are used. The selected period of claims is not to end more than twenty-four months nor less than twelve months prior to the July 1st day on which the revised DRG weights are to be implemented. Claim costs are indexed to a common point in time.

Cost Report Used. The WMAP uses the cost report for each hospital's most recently completed reporting period for which an audit adjusted cost report is available to the Department as of the February 28th date prior to the July 1st day on which the revised DRG weights are to be implemented except the Department may, at its option, use audited cost reports it receives later.

Weights Calculated The updated version of the Medicare grouper is applied to claims in order to assign the appropriate diagnosis related grouping (DRG) to each claim. Charges on each claim are adjusted to cost based on the costs per diem and the ratios of cost to charges from the audited cost report of the specific hospital which submitted the claim. The cost associated with each claim is further standardized (or adjusted) for area wage differentials and reduced for the cost attributed to capital and medical education.

The weighting factor for a DRG is determined based on an analysis which relates the average cost of claims under the respective DRG to the average cost of all claims. Weights are established for over 600 DRGs through this analysis. A listing of the resulting DRG weights are disseminated to in-state and major border status hospitals.

A separate DRG weight is established for cochlear implant procedures and devices based on current information, other than described above, for the cost of the procedure and device.

5150 DRG Weights For Psychiatric Stays

DRG payment weights for psychiatric stays are determined on the basis of the following groupings of hospitals. These groupings are based on analysis of historical claims for psychiatric stays which result in each group being assigned its own set of psychiatric stay DRG weights.

a. Milwaukee County Mental Health Complex
b. All other IMD hospitals
c. General medical-surgical hospitals with Medicare-exempt psychiatric units
d. Other general medical-surgical hospitals

Each of the groups, except a., is subdivided by location based on whether or not the hospital is located in Milwaukee County.

If a hospital's psychiatric unit is not Medicare exempt, it may be considered an exempt unit for the purposes of this Plan as is explained in section 11900, item H, "Adjustment for Hospitals With Psychiatric Units Which Are Not Medicare-Exempt".

All hospitals placed in group c. above for psychiatric stays, whether actually Medicare-exempt or deemed Medicare-exempt by the WMAP, are expected to treat patients with psychiatric DRGs in the exempt unit/s. If the Department finds through audit, self-reporting or any other means that a claim was assigned to a psychiatric DRG but the patient was not treated in the exempt unit, the Department will recoup the difference in payment between what was paid under psychiatric group c. vs. what would have been paid under psychiatric group d.

5160 Standard DRG Group Rates

A statewide base rate is established from WMAP paid claims from calendar year 1989. Excluded from the paid claims amounts are the following: (a) payments to hospitals for services not included in the DRG payment system such as, but not limited to, ventilator-assisted patients and AIDS patients' services, (b) capital payments, (c) direct medical education payments, (d) indirect medical education payments, (e) disproportionate share adjustment payment, and (f) outlier payments. The paid claims amounts are adjusted to include additional funding provided by the state's budget to assure that the projected reasonable and necessary cost of an economically and efficiently operated hospital is covered in the rate year.

Based on analysis of the adjusted payment data, the statewide base rate is adjusted to provide consideration for variances between (1) general medical/surgical hospitals and hospital IMDs, and (2) hospitals in an HMO mandated county and hospitals in all other counties. The result is a standard DRG rate for each of the following four groups.

-- General Medical and Surgical Hospitals in Milwaukee County
-- General Medical and Surgical Hospitals not in Milwaukee County
-- Hospital IMDs in Milwaukee County
-- Hospital IMDs not in Milwaukee County

Enrollment in the HMO Preferred Enrollment Initiative (PEI) has been mandatory for Milwaukee County Medicaid recipients for over ten years. Because the non-HMO, fee-for-service Medicaid population in Milwaukee requires more intensive medical care and is more costly to care for than the fee-for-service Medicaid population in other counties, the standard DRG group rates will be 10% greater for Milwaukee County hospitals than for hospitals in other counties to allow for any HMO adverse selection occurring in Milwaukee. If the HMO/PEI ceases to be mandatory in Milwaukee County, the WMAP will eliminate the Milwaukee county-wide adverse selection adjustment from hospital-specific DRG base rates. A specific hospital may request an administrative adjustment under section 11900, item I, "Adjustment for PEI Ceasing to be Mandatory."

5200 HOSPITAL-SPECIFIC DRG BASE RATE

5210 Calculation Of Hospital-Specific DRG Base Rate, General

The "hospital-specific DRG base rates" is calculated as follows. Detailed descriptions of each element of the calculation follow this general description. An example of the calculation is in the appendix, section 22000.

The standard DRG group rate appropriate for the hospital is selected according to section 5160.

The labor portion of that group rate will be adjusted by the wage area index applicable to the hospital. The sum of the adjusted labor portion and non-labor portion is the total labor adjusted group rate. Section 5220 describes the wage area adjustment index.

The total labor adjusted group rate will be multiplied by the allowed adjustment percentage for each of the following adjustments for which the hospital may qualify: indirect medical education described in section 5230, disproportionate share described in section 5240, rural location described in section 5260, and IMD hospital length of stay adjustment described in section 5270. Compound multiplication will be used, meaning that each successive product will be multiplied by the adjustment percentage added to one (1.00).

Added to this adjusted rate is a hospital's specifc base payment for capital and a hospital's specific base payment for direct costs of a medical education program, described in sections 5400 and 5500.

The result is the "hospital-specific DRG base rate".

5220 Wage Area Adjustment Index

5221 Introduction.
The standard DRG group rate applicable to a hospital will be adjusted by a wage area index. This subsection describes how the Department develops wage area indices and which index will be applied to a specific hospital. The wage area indices which are to be used for the current annual rate update are listed in appendix §27000.

5222 Wage Area Classification.

Areas. Wage areas are identified by the metropolitan statistical areas (MSAs) and the rural areas which are used by HCFA in the Medicare program as of March 31 prior to the beginning of each rate year. These wage areas in Wisconsin are defined by the counties in each wage area. The Milwaukee MSA includes four counties. The Department has divided the Milwaukee MSA into two wage areas, a Milwaukee county only wage area and an Ozaukee-Washington-Waukesha counties' wage area.

Reclassification. A hospital is originally classified to the wage area in which it is physically located. However, if the Medicare Geographic Classification Review Board has reclassified a hospital to a wage area, other than the area of its physical location, the hospital may request the Department to recognize the reclassification for determining WMAP reimbursement rates. A written request for reclassification must be delivered to the Department by April 30 prior to the beginning of a new rate year. (For details, see administrative adjustment under section 11900, item F, "Adjustment to Hospital Wage Area".) For any hospital Medicare reclassified to the Milwaukee MSA, the Department will reclassify to the Ozaukee-Washington-Waukesha county wage area, not the Milwaukee county only wage area.

After all reclassifications are finalized for any rate year, hospitals in a wage area will be referred to as either,

(1) "remaining original hospitals" which are hospitals physically located in the wage area and which have not been reclassified to or from the wage area, or
(2) "reclassified hospitals" which are hospitals not physically located in the wage area but which have been reclassified to it.

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5223 Calculation of Wage Area Indices. The Department will develop wage area indices based on hospital wage data available through the federal Health Care Financing (HCFA). Specifications identifying the HCFA wage data used for the current rate year indices is identified in appendix 27000. For hospitals for which HCFA has no data, such as childrens hospitals and IMDs, the Department may use data from other sources, if available. The developed indices will reflect the reclassification of hospitals out of a wage area and into another wage area.

Only wage data from hospitals certified as providers for the WMAP will be used. For determining indices for border status hospitals, both major and minor border status hospitals in each wage area will be used. Out-of-state hospitals, which do not have WMAP border-status, will not be included in the calculation of the indices for border-status hospital wage areas.

A statewide average wage rate will be calculated using wage data from WMAP certified hospitals located in Wisconsin. The average wage index for each wage area shall be the ratio of the average wage for the respective wage area to the statewide average wage. The statewide rate, in essence, has a 1.00 index. A wage area index of 1.05 means that the average wage rate for the area is 5% greater than the statewide average. A wage area index of .90 means that the area's average wage rate is 10% lesser than the statewide average.

The average statewide and area wage rates shall be the average of individual hospitals' average wage weighted by the individual hospitals' amount of staff. As a result, larger hospitals will have a greater impact on the statewide and area average wage rate than smaller hospitals.

For each wage area, three indices will be calculated:

(1) a "composite" index which includes wages for the original remaining hospitals and the hospitals re-classified to the wage area,

(2) an "original remaining hospitals'" index based on wages of only the original remaining hospitals in a wage area,and

(3) a "reclassified hospitals'" index based on wages of only the hospitals reclassified to the wage area.

5224 Determining Applicable Index.

If the composite index is significantly lesser than the index for the original remaining hospitals in the wage area, then the index for the original remaining hospitals will be applied only to the originally remaining hospitals in the wage area. The reclassified hospitals' index will be applied only to hospitals reclassified to the wage area.

If the composite index for a wage area is not significantly lesser than the index for original remaining hospitals in the wage area, then the composite index shall be applied to both the original remaining hospitals and the hospitals reclassified to the wage area.

Significantly lesser means the composite index for a wage area is lower than the index of original remaining hospitals in the wage area by an amount exceeding one-percent (1%) of the index for the original remaining hospitals in the wage area.

The index applied to any hospital located in Wisconsin shall not be lesser than the rural Wisconsin index as determined under section 5225.

5225 Rural Wage Area Indices.

The wage index for the Wisconsin rural area will be based on wage data for only the original remaining hospitals in the rural area and will not include hospitals reclassified from or to the Wisconsin rural area. The wage index for the rural areas of other states will be based on wage data for only the original remaining hospitals in the rural area which are WMAP border status hospitals.

[Note no change as of July 1, 1996 in sections 5226 and 5227. Change is in secion 5230 which is now on next page.]

5226 Recision of Reclassification By Department.

A hospital's reclassification shall be rescinded by the Department if and only if the wage area index to be applied to the reclassified hospital:

(1) is lesser than the index to be applied to the original remaining hospitals in the hospital's area of physical location or,

(2) is lesser than the rural hospital adjustment under section 5260 if the hospital is located in a rural wage area but was reclassified to an urban wage area.

The Department will place all such hospitals into the wage area of their physical location, recalculate wage area indices according to the methodology described in section 5223, and again determine the applicable indices according to section 5224.

5227 Recision of Reclassification by Hospital.

If the Department has approved a hospital's administrative adjustment request for reclassification to another wage area, the hospital may request recision of their reclassification through the administrative adjustment under section 11900, item F. The Department may accept such a recision request and place the hospital back into its wage area of physical location if, and only if, the wage area index applied under section 5224 to the requesting hospital, (1) is lesser than the index to be applied to the original remaining hospitals in the requesting hospital's area of physical location. and, (2) is lesser than the wage area index applied to the requesting hospital for its rate in effect on June 30th of the preceding rate year. A hospital must request recision within the time limit specified by the Department.

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